State of Vermont
Developmental Services
Application Form

Agency _____

Date: _____

Services Requested for: _____

Address: _____ **Phone Number:** (___) ___-____

_____

_____

Date of Birth: ____/____/____ **Social Security Number:** _____-_____-_____

Applicant's Name: _____

Address: _____ **Phone Number:** (___) ___-____

_____

_____

Relationship of Applicant to Individual: ☐ **Self** ☐ **Guardian** ☐ **Family**
☐ **Agency** **(with person's/guardian's consent)**

		Yes	No	Policy Number
Insurance:	**Medicaid**	☐	☐	_____
	Medicare	☐	☐	_____
	Other _____			_____

Legal Guardian: ☐ **Private** ☐ **Public** ☐ **None**

Guardian's Name: _____

Address: _____ **Phone Number:** (___) ___-____

_____

_____

Intake Questions:	**Yes**	**No**
▪ **Do you believe you, or the person you are applying on behalf of, has a developmental disability (i.e., diagnosis of mental retardation or pervasive developmental disorder)?**	☐	☐
▪ **Are you or the person you are applying for a resident of Vermont ? Lived in Vermont since _____ (date)**	☐	☐
▪ **If not, please explain on the back of the application why you are applying now.**		
▪ **Are you, or the person you are applying on behalf of, in crisis and in need of immediate services?**	☐	☐

Indication of Approval by Person &/or Guardian _____ **Date** _____

Signature of Applicant (if different) _____ **Date** _____